Poor Health, Lone-mothers and Welfare Reform: Competing Visions of Employability

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Welfare-to-work research has revealed many constraints for beneficiaries attempting to leave social benefits to survive on employment income, including low confidence levels, dead-end jobs, low pay, unfavourable tax rates and childcare problems. Little is known about health-related constraints even though researchers have long been aware of the correlation between low income and poor health. This article is derived from a New Zealand project examining the health of lone-mothers on welfare and how health and other factors affect their ability to engage in paid-work. Stories from 120 interviews with work-tested sole-mothers illustrate their concerns when they are expected to find paid-work despite having sick children, poor health of their own, multiple family problems and depression. These stories, which coincide with research in other countries, are contrasted with neo-liberal welfare policy, suggesting competing visions of employability. As all ‘liberal’ welfare regimes are restructuring in similar ways, this project is relevant to other nations.

Social researchers have long known that people living in impoverished circumstances are more prone to ill health. The link between poverty and poor health suggests that wealthier people can afford to purchase more nutritious food, drier and warmer accommodation, better hygiene, warmer clothes, preventative health services, and better care when they become ill. In addition, poor people are more likely to work in dangerous jobs, live in high crime areas and engage in risky lifestyles (Clarke, 2000). Canadian research reveals a compelling link between poverty and poor health (Raphael, 2001) and shows that children in poor families have more than twice the incidence of chronic illness and disabilities as children living in non-poor families (Ross, Scott & Kelly, 1996). They are also more likely to experience social impairments and psychiatric, emotional, hyperactivity, and conduct disorders (Lipman, Offord & Boyle, 1994). British research by Helen Roberts (1997) reports similar findings, noting that childhood poverty is linked to higher sickness and premature death rates.

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Poverty is also associated with political powerlessness and marginalization (Clarke, 2000, p. 54). Economic growth is not necessarily associated with better health for the entire nation but economic decline usually affects living standards and therefore the health of marginalized groups. In the past two decades, both poverty and inequality have increased in many industrialized countries, disproportionately affecting lone-parent and indigenous households (Baker & Tippin, 1999; Raphael, 2001). Low income can result from unemployment, low-wage or part-time work, periods of time outside the labour force, and reliance on social benefits.

Historically, the ‘liberal welfare states’ (Esping-Andersen, 1990), including Canada and New Zealand, set social benefit levels below minimum wages, ostensibly to increase work incentives. In recent years, these states have all developed welfare-to-work programs to move beneficiaries off ‘welfare’ and into paid-work, hoping to reduce social expenditures while improving the life chances of recipient families. Policy analysts have studied how various aspects of social programs push or pull welfare recipients into paid-work. However, they have given little recognition to poor physical or mental health, or how the perception of poor health interacts with other contextual variables to inhibit the successful re-entry into paid-work. Nevertheless, considerable research suggests that some beneficiaries, especially lone-mothers, find it difficult to fulfil the requirements of welfare-to-work programs (Evans, 1996; Edin & Lein, 1997; Mullaly, 1997; Corcoran et al., 2000).

The feminist and non-feminist literature reveals that mother-led families have much higher poverty rates than coupled or lone-father families (Millar & Rowlingson, 2001). Lone-mothers tend to have lower education and job skills than partnered mothers or fathers, and many lone-mothers cannot find jobs with adequate wages to support their families, especially if they pay for childcare services (Dooley, 1995; Vosko, 2000). Their jobs seldom include flexible hours, paid sick leave or extended health benefits and their circumstances often impede progression to higher wages or job security. Studies such as Pryor and Rodgers (2001) report that lone-mothers sometimes experience emotional problems arising from marriage breakdown, continuing disputes with ex-partners, and children’s behavioural problems that interfere with finding and keeping a job. Like others on low incomes, lone-mothers and their children experience a disproportionate degree of physical and mental health problems (Roberts, 1997; Dorsett & Marsh, 1998; Hobcraft & Kiernan, 2001; Sarfati & Scott, 2001).

This paper is situated theoretically within three research themes: the link between poverty and poor health, poor health as a constraint to paid-
work, and the impact of welfare reform on lone-mothers. I argue that welfare reform in liberal welfare states has downplayed the prevalence of poor health among welfare recipients, how poor health interacts with the gendered nature of both paid and care work, and the daily stresses many lone-mothers experience. Using personal ‘stories’ from qualitative interviews with lone-mothers relying on the New Zealand Domestic Purposes Benefit, an income support program for lone-mothers caring for dependent children, the paper discusses how poor health can interact with the difficulties of lone-parenthood and the changing benefit and health systems to impede the successful transition to paid-work.

New Zealand, like Canada and the United States, is used as a case study of a ‘liberal’ welfare state that relies mainly on means-tested benefits, offers few universal social services, encourages more beneficiaries to work for pay, and is altering prevailing definitions of ‘good mothering’. Ill health is only one factor inhibiting the location and retention of paid-work. Yet our study, as well as overseas research, indicates that poor health is a particularly important constraint for lone-mothers because they have been the guardians of family health.

The qualitative interviews discussed in this paper were part of a larger research project on the transition from welfare to work, funded by the New Zealand Health Research Council and involving questionnaires, focus groups and personal interviews. The study was located in three regions on the North Island of New Zealand representing different socio-economic and ethnic areas. These included the relatively prosperous North Shore of Auckland with mainly ‘European’ New Zealanders, a rural area in Northland that is mainly low-income Maori, and a low-income suburb in South Auckland with a large Pacific Island population. Mailed questionnaires (based on the SF-36 instrument) were sent to all DPB lone-mothers in these regions, whose youngest child was aged six and over and who were not exempted from the ‘work test’ for health reasons. The questionnaire focused on their health status and use of health services, and found that these DPB mothers reported much poorer health than other women of comparable age on all eight measures of health. (See Table I and Figure 1). Focus groups with 14 case managers examined the role of health in case management practices and welfare policy. Personal interviews with 120 work-tested lone-mothers on the DPB discussed their family health and welfare-to-work experiences.

This paper focuses on the interviews with the lone-mothers. For these interviews, we wanted to obtain a full list of all these mothers within our designated regions, in order to draw a random sample. However, the welfare department insisted that they send our letter to all DPB mothers meeting our specifications, inviting them to contact us on a toll-free line if
they wished to be interviewed. To encourage participation, we offered a
draw for a large food hamper just before Christmas. Although we
anticipated problems finding participants, more women volunteered to
talk to us than the 60 we had originally planned to interview.
Consequently, our interview sample is larger than expected, non-random
and may over-represent those who have concerns about health or the new
welfare rules. The second half of this paper discusses some of these
women’s stories, emphasizing the various health problems they believe
constrain them from moving off social benefits. However, to understand
their comments and circumstances, some information about the Domestic
Purposes Benefit and the New Zealand (NZ) health systems is necessary.

![Figure 1. Comparison of SF-36 Health Scores of DPB Women and NZ Women](image)

**Table I. Main Issues Preventing Women on the DPB Taking up a Paid Job**

<table>
<thead>
<tr>
<th>Issue Preventing Paid-work</th>
<th>Percentage Reporting</th>
</tr>
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<tbody>
<tr>
<td>The care of children</td>
<td>52.5</td>
</tr>
<tr>
<td>Inability to find a job</td>
<td>38.1</td>
</tr>
<tr>
<td>Lack of Training</td>
<td>30.0</td>
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<tr>
<td>Poor health</td>
<td>29.1</td>
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<tr>
<td>Transport difficulties</td>
<td>27.5</td>
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<tr>
<td>Poor health of child(ren)</td>
<td>21.7</td>
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<tr>
<td>Poor health of other dependants</td>
<td>9.4</td>
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NEW ZEALAND’S DOMESTIC PURPOSES BENEFIT IN COMPARISON TO OTHER LIBERAL WELFARE STATES

In the 1970s, NZ and Australian lobby groups successfully pressured their governments to help lone-mothers care for their children at home, while other countries (such as Sweden and Denmark) invested in subsidized childcare to help mothers combine employment with family responsibilities (Baker, 1995). In 1973, both Australia and NZ created similar gender-neutral benefits that offered income support to all low-income parents caring for children or other sick relatives at home. Women’s organizations in both countries supported the view that children were best cared for by their mothers (Uttley, 2000, p. 444). In NZ, this program, which still exists, is called the Domestic Purposes Benefit (DPB).

Since the 1970s, governments in many countries have amended social benefits to reflect their own political priorities as well as demographic changes and rising program costs. In NZ, all such benefits (including the DPB) were cut in 1991 by the (conservative) National government. Several amendments were also made to DPB eligibility rules, including raising the minimum qualifying age to 18 in 1991, introducing new employment expectations after 1995, a new abatement scheme in 1996, and enforcing new work tests after 1997 (Wilson, 2000, p. 79). After school and school holiday care was also expanded for the children of DPB recipients. Now, lone-parents on the DPB, whose youngest child is aged 14 years or over, must be actively preparing for full-time work unless they are exempted for some reason (including sickness or disability). If the youngest child is between six and 13 years of age, the parent is subject to a part-time work test (15 hours per week). Those with younger children are expected to attend annual planning meetings (WINZ, 1999). The Labour coalition government has recently introduced legislation to make work testing more flexible and personalized rather than adhering to strict age categories. If passed, DPB recipients with preschool children could be asked to seek paid-work.

Although these benefits were designed to be gender neutral, most recipients were women. In 1998, 87% of recipients of the DPB were women. Of all recipients, 94% of recipients were sole-parents, 2% were women alone and 4% were people caring for sick or infirm family members. Almost three-quarters of DPB recipients are separated or divorced (Wilson, 2000). Only 9% are under the age of 20, while three-quarters are between 20 and 40 years old (Wilson, 2000).

In comparison to the United States and Canada, the DPB seems generous, especially in the period of time a lone-mother can draw
benefits. Neither the American states nor the Canadian provinces permit mothers to receive welfare if all their children attend school, unless there are extraneous circumstances such as disabilities. Instead, they encourage or coerce mothers to find employment when their youngest child enters elementary school and often much younger. The United States became the most reliant on welfare-to-work programs when Aid to Families with Dependent Children was changed in 1996 to Temporary Assistance for Needy Families (TANF) and entitlement was severely restricted (Ellwood, 2001). The American TANF program now limits aid to two years, or five years over a lifetime, but has also increased tax credits and childcare support (Ellwood, 2001). These welfare reforms make American lone-mothers more reliant on paid-work than their counterparts in other liberal states. Nevertheless, many New Zealanders believe that mothers with school-aged children face too many constraints to work full-time.

International research indicates that the effectiveness of welfare-to-work programs varies with the type of beneficiary, their qualifications, wages and employment benefits, the strength of the local economy and the generosity of government services. Jurisdictions vary in their subsidies for childcare and healthcare and their benefits for parenting. North American research suggests that voluntary employability programs lead to a modest substitution of earnings for welfare and can be cost-effective in areas of high job growth (Lightman, 1995; Evans, 1996; Torjman, 1996). Participants without recent employment experience, however, have limited opportunities to develop skills, move to higher-paid jobs or improve their income, but some welfare savings are apparent for governments.

When jobs are scarce, ‘workfare’ or compulsory employability programs help create a pool of cheap labour and marginalized workers who displace existing employees (Gueron, 1995; Shragge, 1997). Furthermore, those who exit from welfare and enter employment tend to remain poor (Edin & Lein, 1997; Lightman, 1997). Workfare programs tend to place people in jobs that do not permit them to escape the welfare system because these programs necessarily involve low skilled and poorly paid-work with few prospects, performed by people with few skills and little confidence (Hardina, 1997). Participants are given false hope about their chances of finding well-paying work that enables them to be self-supporting and beneficiaries sometimes enter a revolving door of welfare to work to welfare (Baker & Tippin, 1999).

‘Welfare mothers’ who move into paid-work are most likely to remain employed if they have prior work experience, more than 12 years of schooling and fewer than three children (Harris, 1996; Cancian et al., 1999). Job instability is also related to employer discrimination,
inappropriate work behaviours, substance abuse, family stresses, partner violence and health problems. Most women find jobs but their wages are insufficient to cover their expenses. Those who manage do so with free childcare, regular child support, shared accommodation or access to transportation (Edin & Lein, 1997). As there is very little research on this topic from NZ, we have drawn heavily on the North American and Australian literature and assume that these findings are pertinent to the NZ situation.

**THE NEW ZEALAND HEALTH SYSTEM AND LONE-MOTHERS**

The first Labour government created an extensive public health system in the 1930s but the restructuring of the 1980s and 1990s reduced health subsidies and introduced larger user fees. Now, the NZ system is more costly to the patient than in Canada, Australia and Britain in terms of physician visits. For example, visits to family physicians (except for preschool children and pregnant women) cost about $45, although diagnostic tests are often free and prescriptions are heavily subsidized. Recipients of social benefits can receive a Community Card that reduces the cost of physician visits to $25 and further subsidizes prescriptions. Visits to hospital emergency wards also require user fees even though NZ has public accident compensation insurance (Barnett & Barnett, 1999).

In addition to the Community Card, some DPB mothers would be eligible for temporary work exemptions and for additional sickness and disability benefits to defray health expenses. However, the high winter rainfall in Northland and Auckland, lack of central heating, and substandard housing all contribute to health problems. Winter indoor temperatures hover around 10-15 degrees Celsius, encouraging the growth of mould and bronchial ailments. In addition, these families are often short of food money as well as preventive health care.

**PAID-WORK AND WOMEN’S HEALTH**

Although few studies have focused on poor health and the transition to paid-work, health often surfaces as one of several constraints. Shaver et al., (1994) interviewed Australian women at the end of their eligibility for the Sole Parent Pension (like the Domestic Purposes Benefit) and found that a third reported health problems interfering with training or employment. Riccio and Freedman (1999) found that health and personal problems made continuous employment impossible for one third of participants in a California welfare-to-work program.
The Australian Longitudinal Study on Women’s Health (1995-2000) found that employed women report better health than women without paid employment (Bryson & Warner-Smith, 1998). However, the authors note that this may reflect self-selection factors: Women in poor health are unable to find or retain work. In Britain, Baker et al., (1999) compared 719 lone-mothers with 8779 partnered women to test the hypothesis that paid-work would improve their health, as this idea had been postulated in welfare-to-work policy. First, they found that lone-mothers were significantly more likely to report poorer well-being and to have a major depressive disorder. Second, they could identify no significant relationship between employment and better health for lone-mothers. In fact, employed lone-mothers were more likely than those who remained at home to report minor respiratory symptoms. This study suggests that the transition from welfare to work is unlikely to improve the health of lone-mothers.

Whitehead, Burström and Diderichsen (2000) found that lone-mothers reported poorer health than partnered mothers in Britain and Sweden, despite more favourable Swedish programs protecting women from poverty and labour market insecurity. Using data from the 1970s to the 1990s and excluding people with permanent sickness preventing work, the researchers concluded that employment prevents poverty among lone-mothers, particularly in Sweden. In both countries, not being employed was associated with poor health but the relationship was stronger in Britain and stronger for lone-mothers. Whitehead et al., propose three hypotheses about the relationship between lone-motherhood and poor health. Lone-mothers may suffer from ‘time poverty’, elevating their stress and illnesses. The work they do compared to married mothers may be more stressful and dangerous. And finally, they may suffer from lower social support. These factors may help to explain the poorer reported health of Swedish lone-mothers despite the low levels of poverty, high standards of housing and relatively generous social services.

Cook, Raine and Williamson (2001) interviewed lone-mothers in Alberta, Canada, where the welfare-to-work program expects them to search for work when their youngest child is six months old. These mothers wanted to care for their children but worried about unpaid bills and how to search for work without childcare. Inadequate social benefits encouraged unhealthy choices, such as skipping meals so their children could eat or buying less nutritious but filling foods. The authors conclude that the Alberta welfare program overlooks women’s caring role by expecting them to search for work without guaranteeing childcare.
Furthermore, the government compromises family health by keeping benefit levels so low. These studies all suggest that poor health is more important to the transition to paid-work than we previously thought.

Our interviews with lone-mothers were rich with details about many aspects of their lives and their relations with the welfare department, but only a few examples can be presented in a paper this length. Interview comments have been extracted that focus on children’s health, the mother’s physical health, multiple family problems, and mental health issues. Family health problems were related to high stress levels, unemployment, substance abuse and overcrowded living conditions. Many of the lone-mothers reported depression, which they attributed to the breakdown of their marriages and the stress of caring for children alone with constant financial worries. The following excerpts from the interviews illustrate these issues.

*Children’s Health Problems*

Many of the lone-mothers we interviewed reported that their children experienced health problems requiring constant care. For example, a mother with two of her four children at home has been on the benefit since her marital separation four years ago. In explaining her reasons for going on the benefit, she said:

…I had no choice. I hadn’t worked since just before (my son) was born. I wasn’t able to work afterwards because he was sick (with asthma, allergies, a heart problem and now behavioural problems). The main reason I can’t get back into the workforce now is, (even though) I am doing a computer course to upgrade my skills on Excel and Powerpoint, the biggest problem is that, although I am very experienced and qualified in an office, I am 56 years old. I have a child who, when he is sick, I have to stay home. During the school holidays I have to stay home, as there is nobody to look after him. He has nobody but me.

Another lone-mother lives with her two daughters while her mother resides downstairs. Although this woman has a master’s degree, she has been on the DPB since the birth of her older daughter and is receiving a disability allowance for her. She described her daughter’s situation: “She’s severely autistic so she doesn’t talk. She’s still in nappies. She needs feeding. She needs constant supervision because, yeah, she’s got no idea of safety. So although she’s mobile, she still has a wheelchair. She’s constantly on the move, she doesn’t sleep so well.”
This lone-mother has recently found part-time residential care for her daughter but also cleans and cooks for her own mother. She has refused several jobs because of her ‘family responsibilities’ and has been turned down for others because she is over-qualified. Now she works about six hours a week. In talking about her financial future she said: “The hardest part, I think, is that as I am getting older, my need to secure my future is getting more pressing, but my ability to do it is getting less. Career-wise, I can’t establish a career. Even the part-time work I do really messes things up …” (she is referring to the fact that her benefits are cut as her earnings increase.

A woman, with two adolescent children, has considerable previous work experience but upgraded her employment qualifications while on the DPB after leaving an abusive marriage. Although working part-time, she is now being pressured to find full-time work but claims that she cannot as her daughter is severely depressed and has a heart problem. She felt that her case manager showed her no empathy and was more concerned with her own job performance than assisting her client:

She doesn’t have children and she can’t even imagine what it must be like to have to work and be exhausted all the time because you are looking after a sick child. If I had my choice, I would have left my job and totally been with my children... The policies need to be more flexible to account for individual situations. Both my past two case managers, I think, have been driven by the incentive bonuses that they have. They mentioned to me that if they get me off the DPB, they would be rewarded.

Many employed mothers talked about children’s minor sickness as a big problem for them. Because they have sole responsibility for their child, they can either force the child to pretend he is well and go to school, or take time off work to care for him or her at home. One lone-mother with two boys is now trying to establish her own business at home partly because of this concern. She said:

If the (children) are sick while you’re at work ... while you’re working, somehow you know you’ve got to say to your boss, oh I’ve got to go home. They don’t like that too much! What else? If they’re not very well, you sort of say to them, well, sorry you’ve got to go to school when it would be better... I know that when they are not very well, it’s actually better to have them in bed for a day to recover. Whereas if you just keep them going and going and going until they get so sick, you’re in a worse position.
Another mother has been on the DPB since she returned to New Zealand eight years ago, pregnant. Although her case manager offered her a disability allowance for her asthmatic son, she declined to accept it because she said she had to pay the doctor $25 to fill out the form in order to receive an extra $1.80 a week on her benefit. When asked about her son’s health she answered: “Winter time is really bad. Up until two weeks ago I had a debt at my doctor for this winter alone... and my debt was $325!” She reported that she had to take her son to the doctor:

Sometimes two, three times a week and I’d get charged $25... As it gets colder (on winter nights), (the asthma) gets worse and worse so I have to run an overnight heater just to keep the air at a certain temperature... So then I get a really big power bill... This winter he has been the worst that we’ve had. He’s popped both eardrums...

This woman has arranged to work near her son as part of her work requirements but her jobs are clearly low-level and not very lucrative. In discussing her own health, she said:

I don’t go to the doctor myself, ever. I had pneumonia last year and didn’t go and ended up getting pleurisy... I finally went up there (to the doctor) and he said: ‘My God, you’re a sick woman. You need to be in the hospital’. And I was, like, yeah, well I’m a single- mother, so flag it. I’ll just go back home and carry on!... Financially, I often thought of prostitution to get by, which is a really horrible thought, but when you can’t provide, you know, it’s like, what do you do? Most of the groceries I buy are for my son... In the last six months, I’ve lost about eight kilos ‘cause I just can’t afford to feed me too much’...

Although some of these mothers appear to use their children’s illness as an excuse not to enter paid-work, most take their mothering role seriously and sincerely want the best for their children. Some mothers report that they are queried by potential employers about care arrangements for their children. Their paid jobs come with little sick leave and they must take unpaid leave when their children require longer care if they have no childcare assistance from family or friends. Few social services are available to assist them to combine paid-work and childcare, especially for a child with health problems. Some mothers with child health problems make “deals” with doctors and pharmacists to delay payment
or use their food money for health reasons and later return to the welfare office for a food voucher. They also tried to work as much as possible to pay their extra health-related bills even when their own health is poor. For many lone-mothers in our study, the health subsidies on physicians’ fees appear to be far too low.

**Poor Physical Health of Mothers**

The comment above, about not going to the doctor for their own ailments, was typical of many lone-mothers we interviewed. Especially those on prolonged low incomes reported health problems of their own, even though our sample was not supposed to include women exempted from the work test for disability or health reasons. A mother of two has been on the benefit for over a decade, went back to university (while receiving the DPB) to upgrade her education, but had to quit due to poor health. She mentioned that she had arthritis and cancer, but had not told the welfare office much about her health problems. She is now working at three part-time jobs to try to pay her bills. In talking about her own health, she said:

I have got cancer, so it pretty much stomped on everything and a lot of the reason I couldn’t fight it at the time and I ended up... I got pneumonia and I... then I got post-viral and it was all ‘cause I was doing too much... We (lone-mothers) feel cornered and we come out fighting and end up doing too much, which is probably what I’m doing at the moment.

When asked if she discusses her health problems with her case manager, she replied:

Personally, I say as little as possible, as little as possible, because it just comes back and bites you... I’m finding that if I shut up and don’t say anything and just give yes and no answers basically, and say the absolute minimum, they’re quite happy with that. It’s when you actually sit down and tell them everything that they want more... they want more...

The fact that this woman has not reported her medical condition means that she doesn’t have a medical exemption and her case manager therefore would pressure her to work more hours per week than her doctor would recommend. Yet she was reluctant to reveal too much about her “weaknesses” for fear that her case manager would somehow use this information against her.
Another woman lives with her asthmatic daughter, while her son (who suffers from migraines) resides with his father. She told us she had cancer when she was pregnant with her daughter and has just been diagnosed with a serious chronic disease. Recently, she quit her part-time job for health reasons but her case manager disapproved and cut her benefit. She angrily reported the conversation with her case manager when she asked for a food voucher:

I got a medical certificate. She’s seen it. She signed it and I mean it is so frustrating... I’ve got no money. My daughter, I mean, shit, we’re onto our last couple of slices of bread. When I say we have no food, I mean we have no food and it was just so frustrating because this woman turned around and said to me: ‘You’re working!’ And I said: ‘No I’m not’!

This beneficiary was angry because the case manager cut her benefit and then called her former place of work to verify that she really had resigned. Meanwhile, she had no food and had to borrow money from a neighbour.

A mother of two children, who has been on the DBP for sixteen years, discussed her arthritis with the interviewer, and how it made it difficult to find paid-work:

There’s pain, but as I say, I just push through that, but it leaves me exhausted... I can’t actually see that improving. I’d say I’m going to be like this pretty much from now on... that’s the thing. When you’re in low-paid jobs, they’re physical jobs which is exactly what I can’t do anymore.

Later in the interview, she said that her case manager and the welfare office was not interested in client’s health or her mothering duties, and how they might interfere with paid-work:

They just don’t care... unless you’re down... and can’t walk, they don’t care... it’s like, what can you do for 10 hours? Can you make it through 10 hours? Even if you’re... you’re crawling to the finish line, can you do it? They don’t take into account that after that, you’ve got to come home and look after the kids. You’ve got to cook the meals... do the washing and... do the reading with them at night. That’s not taken into account. That doesn’t count because work is the focus.
This last comment highlights how health interacts with other aspects of life. Mothers need to be healthy enough to work and to care for their children at the end of the work day. A similar comment was made by a Northland mother of two, who has been on the DPB for 10 years. She is currently out of work and reported that back problems prevented her from taking certain jobs:

I had to stop work for about three months at one stage because of extreme pain but I also get regular osteopathic treatment. A lot of it seems to have been stress related over the years, which becomes a physical thing. But so long as I keep myself fit and strong then I can keep a lid on that... I... I tried to put my family first and I mean some jobs, like any heavy lifting work and things, there’s been times like when my back’s been so bad so I haven’t done that kind of work, whereas other times I have been able to... it wouldn’t be fair for me to take on a full-time position because I wouldn’t, I know I wouldn’t be able to give my all to that job...

Another mother with two children at home and the care of both elderly parents said:

I managed to get more hours in my job so I got rid of the income support and I was working full-time. I did that for four years... but (had) to go back on the DPB... I got industrial deafness from my job and I started being harassed... (My supervisor) would give me all the dirty jobs and my life became a misery working there in the end. I started getting sick because I started stressing out...

Many of these women cope with their own poor health and children’s health problems at the same time that welfare officers pressure them to find paid-work or increase their work hours. In most cases, lone-mothers with medical certification would receive a temporary exemption from the work test until their health improved but some women in our study withheld information from their case manager. They feared that any change in status would lead to further stigmatization, intrusive personal investigations or a reduction of their already low income.

Multiple Family Problems

Many of these families, especially in South Auckland and Northland, experienced multiple family problems relating to violence, alcoholism and poor health that made their lives very challenging. For example, a lone-mother with many children, plus the care of a nephew (with alcohol and mental health problems), was left by her husband ten years after
immigrating to New Zealand from a Pacific Island. She had been working as an agency nurse, but when her husband left her, she reduced her hours and eventually stopped working to care for her children as she had no acceptable childcare. When asked about her children’s health, she mentioned that several had asthma, bad enough to be admitted to hospital. Later, she told the interviewer that she had returned to school to upgrade her nursing qualifications but her own health deteriorated after a series of financial and personal problems and she was admitted to hospital with appendicitis. She took a long break from studying but has now returned to finish her training.

A mother of four has been on the DBP about four years, worked full-time for a year, and now has been back on the benefit for a year. She said that she went on the DPB when “the police took my husband”. She told the interviewer that her husband beat her but pointed to her daughter and said: “Hubby - he beat her to a pulp!” She provided some details of her family life:

The father of the three (older children)... is a total alcoholic, so we didn’t have a family life at all and the children didn’t have a father. So we separated and I met (my ex-husband). He was a real knight in shining armour but I... we got married and all hell broke loose.

After five miscarriages, she had her youngest daughter through *in vitro* fertilization, but was in poor health throughout pregnancy and was in intensive care during childbirth:

That night, they didn’t expect me to make it, so they made up the bed next to me in intensive care for (my ex-husband), and he walked out and left me to die!... So when he abused (my daughter) to the extent he did that day, he really put a weapon into my hand to use to get him out, and I used it.

She also told the interviewer that she had a serious back problem but: “I’m 50 next year and want to do some job to take me into my sixties. You know, I want to get ahead of it”. She had been working in the local department store on the weekends but had to resign because of childcare problems. When the interviewer asked if she had recent opportunities to work that she hadn’t been able to take up because of personal or family problems, she replied:

I’d say this year I have. I’ve been in and out of hospital. I burst a disc in my back about April. So I am under a specialist in
Auckland and they did a study of me and all my discs in my back are going. And I got bitten by a white-tailed spider. So I was in hospital for that and now they’ve just booked me in to have my gallstones done and that’s next week.

Later in the interview she talked about an incident about five years ago:

When I had my hysterectomy, (my daughter) was 18 months (old) and I was by myself. I went in (to hospital) on the Tuesday, operated on the Wednesday, out on the Friday and full on board on Saturday, having to do everything. I had an 18-month-old baby and a sick one at that. She had gastroenteritis...

She talked about a recent visit to the doctor:

I went for my gallstone and (the doctor) sat me down and gave me a good telling off. He said: ‘We find with you, you let things go too far before you come to see us.’ He said: ‘You’ve got to start letting us know when you’re just... you know’. But I think you will find that with most solo-mothers.

A Maori woman with three children was very downcast and quiet during the interview. She came from an abusive relationship and as a result, has lost movement in one arm and still experiences pain. As an unskilled worker, she reported considerable difficulty finding work with her disability (which is not considered to be severe enough to exempt her from the work test):

I could have started as a cleaner but I knew (my arm) would play up. I can’t even lift... Sometimes it looked like the job was good but the amount of work involved, I couldn’t do. The (other) workers don’t like it if you don’t carry your weight.

In our interviews, we found that most of these lone-mothers could not afford preventive health care or to visit the doctor for their own ailments. Moreover, many of these women and children lived in dangerous and stressful conditions. These constant pressures, with no end in sight, led to high rates of depression among the lone-mothers in our study.

*Mental Health Issues and Lone-motherhood*

Mental health problems are widespread among lone-mothers according to previous research as well as our own questionnaire. In one of our
personal interviews, a mother of two has been on the DPB since she left her husband 11 years ago. She mentioned that he had beaten her regularly throughout marriage but she left him when she began to worry about her infant daughter’s safety. When she left Australia to return to NZ: “I suppose I was a mess, really. I didn’t want to be a sole-parent. That’s the last thing I wanted to be.” Although she had a mental breakdown, she did not receive any counselling. Her mother came over from Australia to help look after the children, but she fell ill and could not receive social or health benefits in NZ. Eventually her mother returned home leaving her daughter to cope on her own. The DPB mother, who lives in a remote but beautiful part of northern NZ, discussed her depression and feelings of isolation at great length, and below are a few excerpts:

(I’m) just alone and... nothing to look forward to in the future... just to have to live from day to day on my own, parenting all the time and not seeing anybody... not being able to have any dream, or any sort of future sort of plans or just surviving from day to day... especially financially too. Where you’re isolated because you haven’t got enough money to put petrol into the car to go anywhere... Socially, there’s nothing to do really but to go to the pub... we’ve got no entertainment in this town at all. I mean we can go to the beach, and it’s beautiful at the beach, but it’s just me and the kids, you know?

Another mother with three boys has been on the benefit for nearly 11 years since her first child was born but now works for eight hours a week at McDonald’s. Despite depression, she expressed a more positive view about returning to paid-work:

I actually had depression but... I never got a disability allowance for it... It got hard for me when the youngest turned six and I knew I had to go out and get work... I thought my health wouldn’t be up to it. I thought I’ve had so much stress... I didn’t feel (my health) was very good and I just thought I can’t be a mother and go out and get a job... It’s just too much... but once you take that leap it’s not so bad because I’ve done that now. I’ve just got a part-time job and I realise that, you know... it can seem worse than it actually is once you start doing it... Well right now it’s working at McDonald’s, which is not exactly my ideal, but it’s really good because they’re flexible with the hours. I can work within school time and I can take holidays off.
One mother of two boys, on the DPB for most of 16 years, told us that she was already looking for work when the welfare office changed its rules about mothers’ employment. She now works part-time in her local video shop:

I was starting to look (for work) anyway because mentally I was not coping, which happens when you’re at home and not in the real world at all. And I knew I had to get out and I tried a couple of little jobs that had just been absolutely disastrous. Sort of very low paid, high impact jobs, and worked from home once. And I just happened to be in (the video shop) one day and (the owner) said to me, how’s the job going? And I said, that’s it, I’ve, you know, thrown it away. And she said, oh, do you want to work here for a while? And that’s how it started basically.

Some of the mental health problems these women report may have contributed to the breakdown of their relationships and prevented them from repartnering. Nevertheless, the stresses of debt, insufficient money for food or “to put petrol in the car”, the responsibility of caring for children alone, with little social support in some cases, clearly contribute to their feelings of depression and poor mental health. Many mothers reported that they were not offered subsidized counselling even when they clearly needed it and also felt that their case managers did not want to hear about their mental or physical health concerns. Clearly, the accumulation of daily problems puts pressures on lone-mothers’ health but also makes it more difficult for them to cope with health problems that may be considered less constraining to other people. For these mothers, the additional pressure from the welfare office to find paid-work augmented their depression. For others with fewer problems and more social support, getting out of the house and finding paid-work actually reduced their feelings of depression.

CONCLUSION

Social scientists have long known about the correlation between poverty and poor health. In the past few years, more researchers have examined the specific connection between lone-motherhood and ill health yet few studies make the additional link to the implementation of welfare-to-work programs. Our study reinforces other findings that the transition to paid-work is difficult for many low-income mothers. Some continue to deal with the emotional scars from partner abuse, children’s behavioural problems, and financial and childcare problems, all of which interfere with
finding and holding jobs that require commitment and concentration. Mothers on welfare have few resources to pay for healthcare, transport or childcare services, and are justifiably afraid to leave their children with unreliable caregivers, especially when they are sick.

About one third of lone-mothers in our study, as well as other research, report family health problems that make paid employment particularly challenging. While many already had work experience and subsequently developed strong coping skills, others came from impoverished backgrounds, had few job skills, low education, large families and little social support. Many perceived that their case manager did not care about their health even though, in their view, it interfered with the transition to paid-work. We found these problems and concerns in all three socio-economic areas and among women of various ethnic backgrounds.

Our study shows competing visions of employability between DPB mothers and the New Zealand welfare department. These mothers want to support their children but feel that their own health and their children’s well-being are more important than any paid job. Although the welfare system exempts lone-mothers with ‘legitimate’ health reasons from the work test, judgements about health (especially mental health) continue to be contestable. Current welfare policy sees paid-work as a priority for mothers with school-aged children. It pushes lone-mothers to take courses even if they are uninterested and to find jobs even when they feel unready, and punishes them with benefit cuts when they fail to take up these opportunities. Some lone-mothers need and appreciate the push but still require additional services to enable this transition to be effective.

Our research suggests that health-related issues intersect with welfare policies in at least four possible ways. First, lone-mothers and their children can be in good health, and thus health status poses little or no constraint on their ability to undertake paid-work. Second, health status can be poor over the long term and the welfare recipient is exempted from workfare requirements. Third, a beneficiary or her child(ren) can have a temporary health problem, which is assessed periodically, and which leads to a shorter term exemption or deferral from seeking work. Fourth, physical or mental health concerns are not thought to be sufficiently incapacitating or problematic to affect eligibility for labour market involvement. It is this latter area where competing visions of employability manifest themselves most frequently.

Our interviews clearly indicate that health can be a site of consensus, contest and negotiation for both beneficiaries and their case managers. Lone-mothers say that their case managers do not probe health issues when they apply for benefits or are assessed for work eligibility. Some lone-mothers claim that their case managers either do not care,
misunderstand or underestimate the implications of health problems for employment. In yet other cases, women choose not to reveal some health issues because they fear that health will be used as a means of further surveillance, intrusion and control over their lives. Work testing welfare recipients takes health from its personal sphere and brings it into a more public sphere where it is subject to scrutiny and assessment by the state. Beneficiary health issues can then become entangled with power relations between clients and case managers. And at times, divergent views of the ability to work, the suitability of work, working hours and conditions can arise.

Underlying these competing visions is the question of how health is seen within the context of the rest of women’s lives. For many lone-mothers, health problems have dramatic impacts and complications. A mother’s poor health can affect her ability to care for her children, her interactions and activities with the children, their subsequent behaviour, and how scarce financial resources are allocated. In low paid-work and with little negotiating power and sick leave, lone-mothers often struggle to manage time off work for personal illness or to care of their children without losing their jobs. With sole responsibility for the family, low income and lack of state support for some medical expenses, family health problems become more consequential for these women than for other people.

This contextualised experience of health contrasts with that of the welfare state, which tends to adopt a more individualized approach. Although there is some understanding that health affects other aspects of beneficiaries’ lives, welfare practices tend to see the claim of poor health as an excuse to avoid work or just another obstacle (like transport problems or lack of childcare) affecting work capacity. Our research suggests that closer attention should be paid to how poor health can interact with other constraints to paid-work. After all, sick children require special childcare and sick mothers cannot easily take the bus to work.

This project focuses on the policies and practices of one country. Nevertheless, our findings are consistent with studies in the United States, Canada, Australia and Britain. These liberal welfare states have all restructured their social programs to reinforce personal responsibility and job readiness but do not always consider the other factors affecting the transition to paid-work. Our research suggests that policy makers need to give more consideration to programs designed to improve the poor health of beneficiaries, to provide lone-mothers with counselling, to offer better childcare and respite care services, and to improve the government subsidies on physicians fees to enable mothers to remain the guardians of family health while seeking to make themselves more employable.
REFERENCES


